



Commonwealth of Kentucky KY Medicaid

Provider Billing Instructions For Transportation Provider Type – 55-56

Version 5.0

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Document Change Log

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1.1	12/14/2005	EDS	Incorporated revisions and corrections from Commonwealth.
1.2	01/19/2006	EDS	Updated Provider Rep list.
1.3	02/22/2006	Carolyn Stearman	Updated with revisions and corrections from Commonwealth.
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1.7	08/21/2006	Cathy Hill	Updated with revisions and corrections from Provider Relations. Updated formatting.
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4.9	08/16/2012	Stayce Towles Patti George	Section 6.3- Changed Taxonomy Qualifier from PXC to ZZ in form locators 24I and 33B per CO18459. (Update of Provider Inquiry form approved by John Hoffman on 08/30/12)
5.0	10/25/2012	Stayce Towles Sandy Berryman	Appendix A – Updated CMS 1500 Crossover EOMB Form and Instructions DMS Approved 10/29/2012, Jennifer L. Smith

TABLE OF CONTENTS

NUMBER	DESCRIPTION	PAGE
1	General	1
1.1	Introduction	1
1.2	Member Eligibility	1
1.2.1	Plastic Swipe KY Medicaid Card	2
1.2.2	Member Eligibility Categories	3
1.2.3	Verification of Member Eligibility	5
2	Electronic Data Interchange (EDI)	7
2.1	How To Get Started	7
2.2	Format and Testing	7
2.3	ECS Help	7
2.4	Companion Guides for Electronic Claims (837) Transactions	7
3	KyHealth Net	8
3.1	How To Get Started	8
3.2	KyHealth Net Companion Guides	8
4	General Billing Instructions for Paper Claim Forms	9
4.1	General Instructions	9
4.2	Imaging	9
4.3	Optical Character Recognition	9
5	Additional Information and Forms	10
5.1	Claims with Dates of Service More than One Year Old	10
5.2	Retroactive Eligibility (Back-Dated) Card	10
5.3	Unacceptable Documentation	10
5.4	Third Party Coverage Information	11
5.4.1	Commercial Insurance Coverage (this does NOT include Medicare)	11
5.4.2	Documentation That May Prevent A Claim from Being Denied for Other Coverage	11
5.4.3	When there is no response within 120 days from the insurance carrier	12
5.4.4	For Accident And Work Related Claims	12
5.5	Provider Inquiry Form	14
5.6	Prior Authorization Information	16
5.7	Adjustments And Claim Credit Requests	17
5.8	Cash Refund Documentation Form	19
5.9	Return To Provider Letter	21
5.10	Provider Representative List	23
5.10.1	Phone Numbers and Assigned Counties	23
6	Completion of CMS-1500 (08/05) Paper Claim Form	24
6.1	New CMS-1500 (08/05) Claim Form without NPI	25
6.2	Completion of the New CMS-1500 (08/05) without NPI Paper Claim Form	26
6.2.1	Detailed Instructions	26
6.3	New CMS-1500 (08/05) Claim Form with NPI and Taxonomy	30
6.4	Completion of the New CMS-1500 (08/05) Claim Form with NPI and Taxonomy	31
6.4.1	Detailed Instructions	31
6.5	Military Time Conversions	35
6.6	Helpful Hints For Successful CMS-1500 (08/05) Filing	36
7	Emergency Authorization	37
8	Appendix A	38
8.1	Resubmission of Medicare/Medicaid Part B Claims	38
8.1.1	Medicare Coding	38

8.1.2	Medicare Coding Sheet.....	39
8.1.3	Medicare Coding Sheet Instructions	40
9	Appendix B	41
9.1	Internal Control Number (ICN).....	41
10	Appendix C	42
10.1	Remittance Advice	42
10.1.1	Examples Of Pages In Remittance Advice	42
10.2	Title	44
10.3	Banner Page	44
10.4	Paid Claims Page	47
10.5	Denied Claims Page	49
10.6	Claims In Process Page	51
10.7	Returned Claim	53
10.8	Adjusted Claims Page	55
10.9	Financial Transaction Page	57
10.9.1	Non-Claim Specific Payouts To Providers	57
10.9.2	Non-Claim Specific Refunds From Providers.....	57
10.9.3	Accounts Receivable.....	57
10.10	Summary Page.....	61
10.10.1	Payments.....	61
11	Remittance Advice Location Codes (LOC CD)	65
12	Appendix E	66
12.1	Remittance Advice Reason Code (ADJ RSN CD or RSN CD)	66
13	Appendix F.....	68
13.1	Remittance Advice Status Code (ST CD).....	68
14	Appendix G	69
14.1	Transportation Pickup and Destination Modifiers	69

1 General

1.1 Introduction

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

<http://chfs.ky.gov/dms/Regs.htm>

Fee and rate schedules are available on the DMS website at:

<http://chfs.ky.gov/dms/fee.htm>

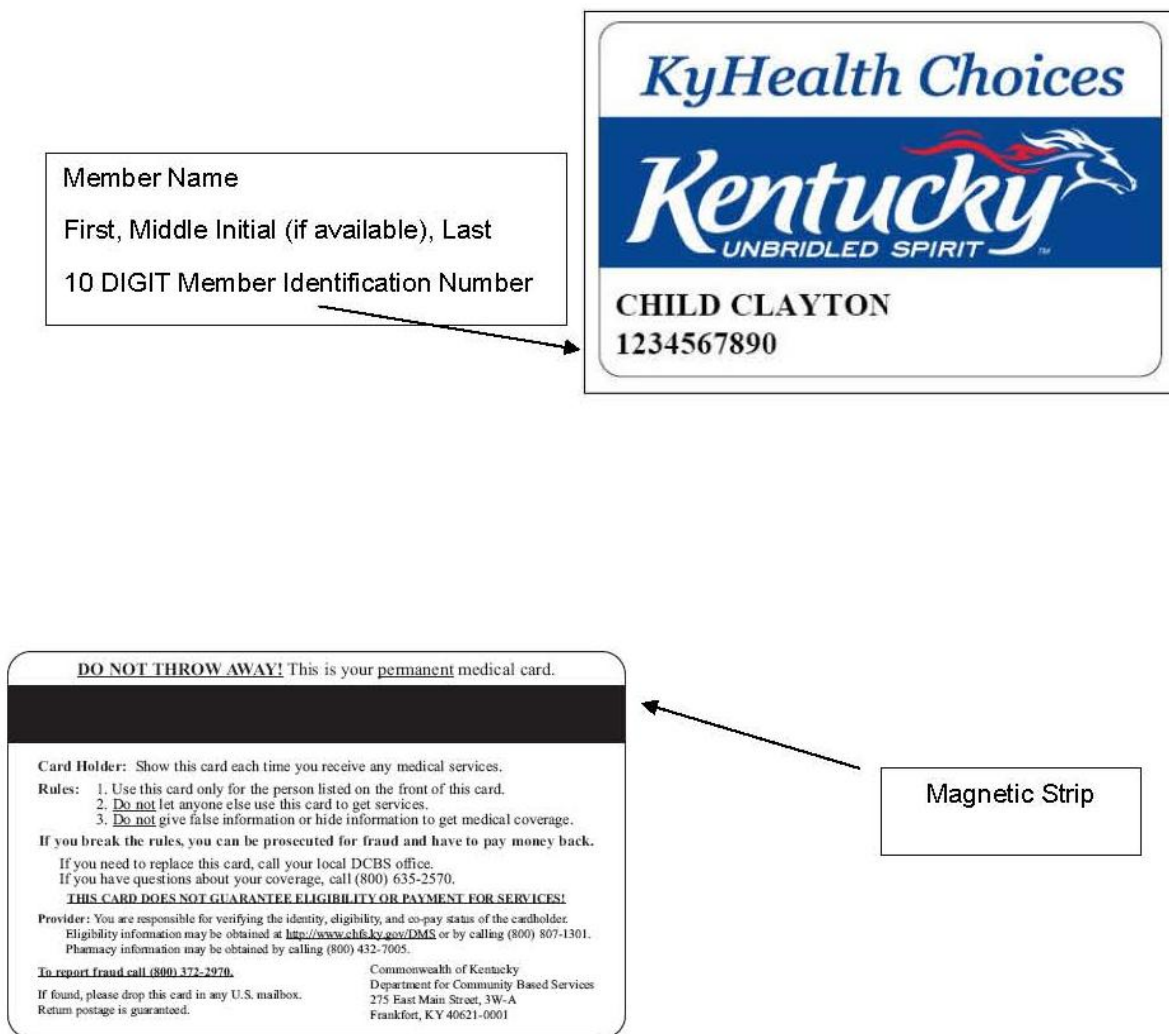
1.2 Member Eligibility

Members should apply for Medicaid eligibility through their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on Holidays.

The primary identification for Medicaid-eligible members is the Kentucky Medicaid card. This is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the member's Medicaid ID number are displayed on the card. The provider is responsible for checking identification and verifying eligibility before providing services.

NOTE: Payment cannot be made for services provided to ineligible members; and possession of a Member Identification card does not guarantee payment for all medical services.

1.2.1 Plastic Swipe KY Medicaid Card



Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

Providers who wish to utilize the card's magnetic strip to access eligibility information may do so by contracting with one of several vendors.

1.2.2 Member Eligibility Categories

1.2.2.1 QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. A QMB Member's card shows "QMB" or "QMB Only." QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

1.2.2.2 Managed Care Partnership

Passport is a healthcare plan serving Kentucky Medicaid members who live in the following counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

The other Managed Care Plans servicing Kentucky Medicaid members are WellCare of Kentucky, Kentucky Spirit Health Plan and CoventryCares of Kentucky. These plans are not county regional as Passport indicated above.

Medical benefits for persons whose care is overseen by an MCO are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with Managed Care plan questions should contact: Passport Provider Services at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Kentucky Spirit Health Plan at 1-866-643-3153 and CoventryCares of Kentucky at 1-855-300-5528.

1.2.2.3 KCHIP

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage to children through age 18 who have no insurance and whose household income meets program guidelines. Children with KCHIP III are eligible for all Medicaid-covered services except Non-Emergency Transportation and EPSDT Special Services. Regular KCHIP children are eligible for all Medicaid-covered services.

For more information, access the KCHIP website at <http://kidshealth.ky.gov/en/kchip>.

1.2.2.4 Presumptive Eligibility

Presumptive Eligibility (PE) is a program which offers pregnant women temporary medical coverage for prenatal care. A treating physician may issue an Identification Notice to a woman after pregnancy is confirmed. Presumptive Eligibility expires 90 days from the date the Identification Notice is issued, but coverage will not extend beyond three calendar months. This short-term program is only intended to allow a woman to have access to prenatal care while she is completing the application process for full Medicaid benefits.

1.2.2.4.1 Presumptive Eligibility Definitions

Presumptive Eligibility (PE) is designed to provide coverage for ambulatory prenatal services when the following services are provided by approved health care providers.

A. SERVICES COVERED UNDER PE

- Office visits to a Primary Care Provider (see list below) and/or Health Department
- Laboratory Services

- Diagnostic radiology services (including ultrasound)
- General dental services
- Emergency room services
- Transportation services (emergency and non-emergency)
- Prescription drugs (including prenatal vitamins)

B. DEFINITION OF PRIMARY CARE PROVIDER – Any health care provider who is enrolled as a KY Medicaid provider in one of the following programs:

- Physician/osteopaths practicing in the following medical specialties:
 - Family Practice
 - Obstetrics/Gynecology
 - General Practice
 - Pediatrics
 - Internal Medicine
- Physician Assistants
- Nurse Practitioners/ARNP's
- Nurse Midwives
- Rural Health Clinics
- Primary Care Centers
- Public Health Departments

C. SERVICES NOT COVERED UNDER PE

- Office visits or procedures performed by a specialist physician (those practicing in a specialty other than what is listed in Section B above), even if that visit/procedure is determined by a qualified PE primary care provider to be medically necessary
- Inpatient hospital services, including labor, delivery and newborn nursery services;
- Mental health/substance abuse services
- Any other service not specifically listed in Section A as being covered under PE
- Any services provided by a health care provider who is not recognized by the Department for Medicaid Services (DMS) as a participating provider

1.2.2.5 Breast & Cervical Cancer Treatment Program

Breast and Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have a confirmed cancerous or pre-cancerous condition of the breast or cervix. In order to

qualify, women must be screened and diagnosed with cancer by the Kentucky Women's Cancer Screening Program, be between the ages of 21 to 65, have no other insurance coverage, and not reside in a public institution. The length of coverage extends through active treatment for the breast or cervical cancer condition. Those members receiving Medicaid through the Breast and Cervical Cancer Program are entitled to full Medicaid services. Women who are eligible through PE or BCCTP do not receive a medical card for services. The enrolling provider will give a printed document that is to be used in place of a card.

1.2.3 Verification of Member Eligibility

This section covers:

- Methods for verifying eligibility;
- How to verify eligibility through an automated 800 number function;
- How to use other proofs to determine eligibility; and,
- What to do when a method of eligibility is not available.

1.2.3.1 Obtaining Eligibility and Benefit Information

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- KYHealth-Net at <http://www.chfs.ky.gov/dms/kyhealth.htm>
- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except Holidays.

1.2.3.1.1 Voice Response Eligibility Verification (VREV)

HP Enterprise Services maintains a Voice Response Eligibility Verification (VREV) system that provides member eligibility verification, as well as third party liability (TPL) information, Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status information.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, check amount, claim status, and so on).
3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member number) as soon as each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and

announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

The telephone number (for use by touch-tone phones only) for the VREV is 1-800-807-1301. The VREV system cannot be accessed via rotary dial telephones.

1.2.3.1.2 KYHealth-Net Online Member Verification

KYHEALTH-NET ONLINE ACCESS CAN BE OBTAINED AT:

<http://www.chfs.ky.gov/dms/kyhealth.htm>

The KyHealth Net website is designed to provide real-time access to member information. A User Manual is available for downloading and is designed to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the HP Enterprise Services Electronic Claims Department at KY_EDI_Helpdesk@hp.com.

All Member information is subject to HIPAA privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

2 Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

2.1 How To Get Started

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the HP Enterprise Services Electronic Data Interchange Technical Support Help Desk at:

HP Enterprise Services
P.O. Box 2016
Frankfort, KY 40602-2016
1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

2.2 Format and Testing

All EDI Trading Partners must test successfully with HP Enterprise Services and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

2.3 ECS Help

Providers with questions regarding electronic claims submission may contact the EDI Help desk.

2.4 Companion Guides for Electronic Claims (837) Transactions

837 Companion Guides are available at:

<http://www.kymmis.com/kymmis/Companion%20Guides/index.aspx>

3 KyHealth Net

The KyHealth Net website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

3.1 How To Get Started

All Providers are encouraged to utilize KyHealth Net rather than paper claims submission. To become a KyHealthNet user, contact our EDI helpdesk at 1-800-205-4696, or click the link below.

<http://www.chfs.ky.gov/dms/kyhealth.htm>

3.2 KyHealth Net Companion Guides.

Field-by-field instructions for KyHealth Net claims submission are available at:

<http://www.kymmis.com/kymmis/Provider%20Relations/KYHealthNetManuals.aspx>

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

4.2 Imaging

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provide efficient tools for claim resolution, inquiries, and attendant claim related matters.

By following the guidelines below, providers can ensure claims are processed as they intend:

- USE BLACK INK ONLY;
- Do not use glue;
- Do not use more than one staple per claim;
- Press hard to guarantee strong print density if claim is not typed or computer generated;
- Do not use white-out or shiny correction tape; and,
- Do not send attachments smaller than the accompanying claim form.

4.3 Optical Character Recognition

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage does not have to be manually typed, thus reducing claim processing time. Information on the claim must be contained within the fields using font 10 as the recommended font size in order for the text to be properly read by the scanner.

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

In accordance with federal regulations, claims must be received by Medicaid no more than 12 months from the date of service, or six months from the Medicare or other insurance payment date, whichever is later. "Received" is defined in 42 CFR 447.45 (d) (5) as "The date the agency received the claim as indicated by its date stamp on the claim."

Kentucky Medicaid includes the date received in the Internal Control Number (ICN). The ICN is a unique number assigned to each incoming claim and the claim's related documents during the data preparation process. Refer to Appendix A for more information about the ICN.

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or HP Enterprise Services and documentation showing subsequent billing efforts, if any.

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date.

Additional documentation that may be attached to claims for processing for possible payment is:

- A screen print from KYHealth-Net verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KYHealth-Net verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);
- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,
- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

5.2 Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligibility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KYHealth-Net card issuance screen must be attached behind the paper claim.

5.3 Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by HP Enterprise Services.

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

5.4.2 Documentation That May Prevent A Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:

- Member name;
- Date(s) of service;
- Billed information that matches the billed information on the claim submitted to Medicaid; and,
- An indication of denial or that the billed amount was applied to the deductible.

NOTE: Rejections from insurance carriers stating “additional information necessary to process claim” is not acceptable.

2. Letter from the insurance carrier that includes:

- Member name;
- Date(s) of service(s);
- Termination or effective date of coverage (if applicable);
- Statement of benefits available (if applicable); and,
- The letter must have a signature of an insurance representative, or be on the insurance company's letterhead.

3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:

- Member name;
- Date(s) of service;
- Name of insurance carrier;
- Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;
- Termination or effective date of coverage; and,
- Statement of benefits available (if applicable).

4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:

- For the same Member;
- For the same or related service being billed on the claim; and,
- The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by HP Enterprise Services if the date of the remittance statement is no more than six months from the claim's date of service.

5. Letter from an employer that includes:

- Member name;
- Date of insurance or employee termination or effective date (if applicable); and,
- Employer letterhead or signature of company representative.

5.4.3 When there is no response within 120 days from the insurance carrier

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to HP Enterprise Services. HP Enterprise Services overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

5.4.4 For Accident And Work Related Claims

For claims related to an accident or work related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to HP Enterprise Services with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

HP Enterprise Services
ATTN: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

5.4.4.1 TPL Lead Form

HP Enterprise Services

*HP Enterprise Services
Attention: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107*

Third Party Liability Lead Form

Provider Name: _____ Provider #: _____
Member Name: _____ Member #: _____
Address: _____ Date of Birth: _____
From Date of Service: _____ To Date of Service: _____
Date of Admission: _____ Date of Discharge: _____
Insurance Carrier Name: _____
Address: _____
Policy Number: _____ Start Date: _____ End Date: _____
Date Claim Was Filed with Insurance Carrier: _____

Please check the one that applies:

_____ No Response in Over 120 Days
_____ Policy Termination Date: _____
_____ Other: Please explain in the space provided below

Contact Name: _____ Contact Telephone #: _____
Signature: _____ Date: _____

DMS Approved: January 10, 2011

5.5 Provider Inquiry Form

Provider Inquiry Forms may be used for any unique questions concerning claim status; paid or denied claims; and billing concerns. The mailing address for the Provider Inquiry Form is:

HP Enterprise Services
Provider Services
P.O. Box 2100
Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the completed form to HP Enterprise Services. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free HP Enterprise Services number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the HP Enterprise Services Voice Response on **1-800-807-1301**.

Provider Inquiry Form**HP Enterprise Services Corporation****Post Office Box 2100****Frankfort, KY 40602-2100**

Did you know that electronic claim submission can reduce your processing time significantly? You can also check claim status, verify eligibility, download remittance advices, and many other functions. Go to www.kymmis.com or contact Billing Inquiry at 1-800-807-1232 for more information. You may also send an inquiry via e-mail at ky_provider_inquiry@hp.com

1. Provider Number	3. Member Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
7. Email	8. ICN (if applicable)	
9. Provider's Message		

10.

Signature

Date

HP Enterprise Services Response: OFFICE USE ONLY

_____ This claim has been resubmitted for possible payment.

_____ This claim paid on _____ in the amount of _____

_____ This claim was denied on _____ with EOB code _____

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

Signature

Date

HIPAA Privacy Notification: This message and accompanying documents are covered by the Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately and delete the original message.

5.6 Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility nor age.
- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.
- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.
- Prior Authorization should be requested prior to the provision of services except in cases of:
 - Retro-active Member eligibility
 - Retro-active provider number
- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the KYHealth Net website to obtain blank Prior Authorization forms.

<http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx>

Access to Electronic Prior Authorization request (EPA).

<https://home.kymmis.com>

5.7 Adjustments And Claim Credit Requests

An adjustment is a change to be made to a "PAID" claim. The mailing address for the Adjustment Request form is:

HP Enterprise Services
P.O. Box 2108
Frankfort, KY 40602-2108
Attn: Financial Services

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;
- Do not send refunds on claims for which an adjustment has been filed;
- Be specific. Explain exactly what is to be changed on the claim;
- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.

HP Enterprise Services

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: HP Enterprise Services
P.O. BOX 2108
FRANKFORT, KY 40602-2108
1-800-807-1232
ATTN: FINANCIAL SERVICES

NOTE: A CLAIM CREDIT VOIDS THE CLAIM ICN FROM THE SYSTEM -- A "NEW DAY" CLAIM MAY BE SUBMITTED, IF NECESSARY. THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A CORRECTED CLAIM AND REMITTANCE ADVICE TO ADJUST A CLAIM.

CHECK APPROPRIATE BOX: CLAIM ADJUSTMENT <input type="checkbox"/> CLAIM CREDIT <input type="checkbox"/>		1. Original Internal Control Number (ICN)	
2. Member Name		3. Member Medicaid Number	
4. Provider Name and Address	5. Provider	6. From Date of Service	7. To Date of Service
	8. Original Billed Amount	9. Original Paid Amount	10. Remittance Advice Date

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

12. Please specify the **REASON** for the adjustment or claim credit request.

13. Signature _____ 14. Date _____

DMS Approved: January 10, 2011

5.8 Cash Refund Documentation Form

The Cash Refund Documentation Form is used when refunding money to Medicaid. The mailing address for the Cash Refund Form is:

HP Enterprise Services
P.O. Box 2108
Frankfort, KY 40602-2108
Attn: Financial Services

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.
- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.
- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

HP Enterprise Services

Mail To: HP Enterprise Services
P.O. Box 2108
Frankfort, KY 40602-2108
ATTN: Financial Services

CASH REFUND DOCUMENTATION

1. Check Number				2. Check Amount			
3. Provider Name/ID /Address				4. Member Name			
				5. Member Number			
6. From Date of Service			7. To Date of Service			8. RA Date	
9. Internal Control Number (If several ICNs, attach RAs)							

Research for Refund: (Check appropriate blank)

- _____ a. Payment from other source - Check the category and list name (*attach copy of EOB*)
- _____ Health Insurance
- _____ Auto Insurance
- _____ Medicare Paid
- _____ Other
- _____ b. Billed in error
- _____ c. Duplicate payment (attach a copy of both RAs)
- If RAs are paid to two different providers, specify to which provider ID the check is to be applied.*
- _____ | _____ | _____ | _____ | _____ | _____ | _____
- _____ d. Processing error OR overpayment (explain why)
- _____
- _____ e. Paid to wrong provider
- _____ f. Money has been requested - date of the letter _____ | _____ | _____
- (attach a copy of letter requesting money)
- _____ g. Other _____
- _____
- _____

Contact Name	Phone
--------------	-------

DMS Approved: January 10, 2011

5.9 Return To Provider Letter

Claims and attached documentation received by HP Enterprise Services are screened for required information (listed below). If the required information is not complete, the claim is returned to the provider with a "Return to Provider Letter" attached explaining why the claim is being returned.

A claim is returned before processing if the following information is missing:

- Provider ID;
- Member Identification number;
- Member first and last names; and,
- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;
- Claim lines completed exceed the limit; and,
- Unable to image.

HP

RETURN TO PROVIDER LETTER

Date: _____ - _____ - _____

Dear Provider,

The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

- 01) ☐ PROVIDER NUMBER – A valid 8-digit provider number must be on the claim form in the appropriate field.
☐ Missing ☐ Not a valid provider number
- 02) ☐ PROVIDER SIGNATURE – All claims require an original signature in the provider signature block. The Provider signature cannot be stamped or typed on the claim.
☐ Missing
☐ Typed signature not valid
☐ Stamped signature not valid.
- 03) ☐ Detail lines exceed the limit for claim type.
- 04) ☐ UNABLE TO IMAGE OR KEY – Claim form/EOMB must be legible. Highlighted forms cannot be accepted. Please resubmit on a new form.
☐ Print too light ☐ Print too dark ☐ Highlighted data fields ☐ Not legible ☐ Dark copy
- 05) ☐ Medicaid **does not** make payment when Medicare has paid the amount in full.
- 06) ☐ The Recipient's Medicaid (MAID) number is missing
- 07) ☐ Medicare EOMB does not match the claim
☐ Dates of Service ☐ Recipient Number ☐ Charges ☐ Balance due in Block 30
- 08) ☐ Other Reason- _____

_____ **Claims are being returned to you for correction for the reasons noted above.**

Helpful Hints When Billing for Services Provided to a Medicaid Recipient

- The Recipient's Medicaid number on the HCFA must be entered Field 9A
- The Recipient's Medicaid number on the UB92 must be entered in Block 60
- Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard/daylight savings time, at 1-800-807-1232.

If you are interested in billing Medicaid electronically please contact EDS at 1-800-205-4696 7:30 AM to 6PM Monday through Friday except holidays.

Initials of clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Phone Numbers and Assigned Counties

JACKIE RICHIE 502-209-3100 Extension 2021273 jackie.richie@hp.com			VICKY HICKS 502-209-3100 Extension 2021263 vicky.hicks@hp.com			PENNY GERMINARO 502-209-3100 Extension 2021281 penny.germinaro@hp.com		
Assigned Counties			Assigned Counties			Assigned Counties		
ADAIR	HARLAN	MCLEAN	ANDERSON	GRAYSON	MERCER	ALLEN		
BALLARD	HENDERSON	MCCREARY	BATH	GREENUP	MONTGOMERY	BARREN		
BELL	HICKMAN	METCALFE	BOURBON	HANCOCK	MORGAN	BOONE		
BOYLE	HOPKINS	MONROE	BOYD	HARDIN	NELSON	CAMPBELL		
BREATHITT	JACKSON	MUHLENBERG	BRACKEN	HARRISON	NICHOLAS	CARROLL		
BULLITT	JEFFERSON	OLDHAM	BRECKINRIDGE	JESSAMINE	OHIO	EDMONSON		
CALDWELL	KNOTT	OWSLEY	BUTLER	JOHNSON	POWELL	GALLATIN		
CALLOWAY	KNOX	PERRY	CARTER	LAWRENCE	ROBERTSON	GRANT		
CARLISLE	LARUE	PIKE	CLARK	LEE	ROWAN	HART		
CASEY	LAUREL	PULASKI	DAVIESS	LEWIS	SHELBY	HENRY		
CHRISTIAN	LESLIE	ROCKCASTLE	ELLIOTT	MADISON	SPENCER	KENTON		
CLAY	LETCHER	RUSSELL	ESTILL	MAGOFFIN	WASHINGTON	OWEN		
CLINTON	LINCOLN	TAYLOR	FAYETTE	MARTIN	WOLFE	PENDLETON		
CRITTENDEN	LIVINGSTON	TODD	FLEMING	MASON	WOODFORD	SCOTT		
CUMBERLAND	LOGAN	WAYNE	FRANKLIN	MEADE		SIMPSON		
FLOYD	LYON	WHITLEY	GARRARD	MENIFEE		TRIMBLE		
FULTON	MARION	TRIGG				WARREN		
GRAVES	MARSHALL	UNION						
GREEN	MCCRACKEN	WEBSTER						

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**
- **Provider Relations 1-800-807-1232**

6 Completion of CMS-1500 (08/05) Paper Claim Form

The following are field specific instructions for billing emergency transportation services on the CMS-1500 (08/05) claim form. Only instructions for fields required for HP Enterprise Services claims processing or for Medicaid Program information are included.

Providers may order CMS-1500 (08/05) claim forms from:

U.S. Government Printing Office
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954
Telephone: 1-202-512-1800

An original CMS-1500, (08/05) claim form should be submitted to EDS. A copy shall be retained by the provider.

Claim forms must be mailed to:

HP Enterprise Services P.O. Box 2101
Frankfort, KY 40602-2106

6.1 New CMS-1500 (08/05) Claim Form without NPI

NOTE: Those KY Medicaid providers waiting for an NPI to be issued may use these instructions for a limited time only. Please watch for future mailings from KY Medicaid for updates. Provider type 56 (Non-Emergency) will continue to use these instructions as NPI and Taxonomy do not apply to Non-Emergency providers.

1500										Sample Only									
HEALTH INSURANCE CLAIM FORM										APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05									
PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1)									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Jane										4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
3. PATIENT'S BIRTH DATE MM DD YY 06 24 42 M <input type="checkbox"/> F <input type="checkbox"/>										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)										7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)									
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>										11. INSURED'S POLICY GROUP OR FECA NUMBER If other insurance makes payment									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: IF APPLICABLE									
a. OTHER INSURED'S POLICY OR GROUP NUMBER 4000000000										a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>									
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE									
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED									
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 123 4 3. 4. 5. 6.										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE EMG C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
10 01 06 41 A0427 RH HR 1										23. PRIOR AUTHORIZATION NUMBER									
25. FEDERAL TAX I.D. NUMBER SSN EIN										28. TOTAL CHARGE \$ 100 00 29. AMOUNT PAID \$ IF APPLICABLE									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 01/01/2012										30. BALANCE DUE									
32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # Transport Company 100 Easy Street Anytown, KY 40601									
SIGNED DATE										a. b. G2 56000000									

NUCC Instruction Manual available at: www.nucc.org

6.2 Completion of the New CMS-1500 (08/05) without NPI Paper Claim Form

6.2.1 Detailed Instructions

Claims are returned or rejected if required information is incorrect or omitted. Handwritten claims must be completed in black ink ONLY.

NOTE: Those KY Medicaid providers waiting for an NPI to be issued may use these instructions for a limited time only. Please watch for future mailings from KY Medicaid for updates.

The following fields must be completed:

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	Patient's Name
	Enter the member's last name and first name exactly as it appears on the Member Identification card.
3	Date of Birth
	Enter the date of birth for the member.
9A	Other Insured's Policy Group Number
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
10	Patient's Condition
	Check the appropriate block if the member's condition is related to employment, auto accident, or other accident.
11	Insured's Policy Group or FECA Number
	Required only if member has another insurance in addition to Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the policy number of the other insurance. Also, complete Fields 11c and 29.
	NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from carrier to the submitted claim.
11C	Insurance Plan Name or Program Name
	Required only if member has another insurance in addition to Medicaid or Medicare and the other insurance made a payment on the claim. Enter the name of the other insurance company. Also, complete Fields 11, 29 and 30.
21	Diagnosis or Nature of Illness or Injury
	Enter the appropriate ICD-9-CM diagnosis code.

24A	Date of Service (Non Shaded Area)
	Enter the date in month, day, year format (MMDDYY) for each procedure.
24B	Place of Service (Non Shaded Area)
	Enter the two digit place of service code. 41 - Ambulance-Land; or, 42 - Ambulance- Air or Water (Valid for provider type 55 only).
24D	Procedures, Services or Supplies CPT/ HCPCS (Non Shaded Area)
	Enter the appropriate HIPAA compliant procedure code identifying the service provided for the member.
	Modifiers (Non Shaded Area)
	Enter the appropriate HIPAA compliant two digit modifier that further describes the procedure code. Modifiers are required on each line to indicate location of pickup and destination. *See Appendix for additional modifiers accepted to indicate location of pickup and destination. If modifiers GM, UA, UB, or UC are appropriate in the billing situation, they must be shown in the first modifier field and followed by the modifier showing location of pickup and destination. GM= ADDITIONAL PATIENT UA = ALS mileage UB= BLS mileage UC= Medical first response Up to four modifiers are accepted.
24E	Diagnosis Pointer (Shaded Area)
	Enter Military Time of Pickup
24E	Diagnosis Code Indicator (Non Shaded Area)
	Enter 1, 2, 3, or 4 when referencing the specific diagnosis shown in field 21 to link the diagnosis to the procedure.
24F	Charges (Non Shaded Area)
	Enter the usual and customary base rate charge. Enter the rate per loaded miles times the number of miles per one-way trip (for example, 20 miles at \$1.50 per mile = \$30.00). Enter the actual invoice charges for disposable supplies and/or extra service charges.
24G	Days or Units (Non Shaded Area)

	Enter appropriate number of units. For base rate, oxygen and supplies procedure codes enter "1" for one way or "2" for round trip. For mileage procedure codes, if the trip is one way, enter the actual number of loaded miles.
24I	ID Qualifier (Shaded Area)
	Enter a G2 to indicate Medicaid Provider NOTE: Those KY Medicaid providers waiting for an NPI to be issued may use these instructions for a limited time only. Please watch for future mailings from KY Medicaid for updates. Provider type 56 (Non-Emergency) will continue to use these instructions as NPI and Taxonomy do not apply to Non-Emergency providers.
24J	Rendering Provider ID # (Shaded Area)
	Enter the eight digit KY Medicaid provider ID 56_____ NOTE: Provider type 56 (Non-Emergency) will continue to use these instructions as NPI and Taxonomy do not apply to Non-Emergency providers.
26	Patient's Account No.
	Enter the member account number. HP Enterprise Servicetypes up to 14 digits. This number appears on the remittance statement as the invoice number.
28	Total Charge
	Enter the total of all individual charges entered in Field 24F. Total each claim separately.
29	Amount Paid
	Enter the amount paid, if any, by a private insurance. Do not enter Medicare paid amount. Also, complete Fields 11 and 11c. NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from the carrier the submitted claim.
30	Balance Due
	Required only if private insurance has made a payment on the claim. Subtract the private insurance payment entered in Field 29 from the total charge entered in Field 28 and enter the net balance due in Field 30.
31	Date
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
33	Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number
	Enter the provider's name, address, zip code and phone number.

33B	(Shaded Area)
	Enter a G2 followed by the eight digit KY Medicaid provider number 56_____. NOTE: Provider type 56 (Non-Emergency) will continue to use these instructions as NPI and Taxonomy do not apply to Non-Emergency providers.

6.3 New CMS-1500 (08/05) Claim Form with NPI and Taxonomy

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Sample Only

123

FOLD HERE / USE ENVELOPE NO. 1500E

<div style="display: flex; justify-content: space-between;"> <div> <div style="display: flex; justify-content: space-between;"> <div> <div>1. MEDICARE</div> <div>(Medicare #)</div> </div> <div> <div>2. MEDICAID</div> <div>(Medicaid #)</div> </div> <div> <div>3. TRICARE</div> <div>CHAMPUS</div> <div>(Sponsor's SSN)</div> </div> <div> <div>4. CHAMPVA</div> <div>(Member ID#)</div> </div> <div> <div>5. GROUP HEALTH PLAN</div> <div>(SSN or ID)</div> </div> <div> <div>6. FECA BLK (LUNG)</div> <div>(SSN)</div> </div> <div> <div>7. OTHER</div> <div>(ID)</div> </div> </div> <div> <div>8. 1a. INSURED'S I.D. NUMBER</div> <div>(For Program in Item 1)</div> </div> </div> </div>											
<div>2. PATIENT'S NAME (Last Name, First Name, Middle Initial)</div> <div>Doe, John</div>				<div>3. PATIENT'S BIRTH DATE</div> <div>MM DD YY</div> <div>06 24 42</div> <div>SEX</div> <div>M <input checked="" type="checkbox"/> F <input type="checkbox"/></div>				<div>4. INSURED'S NAME (Last Name, First Name, Middle Initial)</div>			
<div>5. PATIENT'S ADDRESS (No., Street)</div>				<div>6. PATIENT RELATIONSHIP TO INSURED</div> <div>Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/></div>				<div>7. INSURED'S ADDRESS (No., Street)</div>			
<div>CITY</div>				<div>8. PATIENT STATUS</div> <div>Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/></div>				<div>CITY</div>			
<div>STATE</div>				<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div>				<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>IF APPLICABLE</div>			
<div>ZIP CODE</div>				<div>TELEPHONE (Include Area Code)</div> <div>()</div>				<div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div> <div>If other Insurance makes payment</div>			
<div>9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)</div>				<div>10. IS PATIENT'S CONDITION RELATED TO:</div> <div>IF APPLICABLE</div>				<div>11. INSURED'S POLICY GROUP OR FECA NUMBER</div> <div>If other Insurance makes payment</div>			
<div>a. OTHER INSURED'S POLICY OR GROUP NUMBER</div> <div>4000000000</div>				<div>a. EMPLOYMENT? (Current or Previous)</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>				<div>a. INSURED'S DATE OF BIRTH</div> <div>MM DD YY</div> <div>SEX</div> <div>M <input type="checkbox"/> F <input type="checkbox"/></div>			
<div>b. OTHER INSURED'S DATE OF BIRTH</div> <div>MM DD YY</div> <div>SEX</div> <div>M <input type="checkbox"/> F <input type="checkbox"/></div>				<div>b. AUTO ACCIDENT?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>				<div>b. EMPLOYER'S NAME OR SCHOOL NAME</div>			
<div>c. EMPLOYER'S NAME OR SCHOOL NAME</div>				<div>c. OTHER ACCIDENT?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>				<div>c. INSURANCE PLAN NAME OR PROGRAM NAME</div> <div>If other Insurance makes payment</div>			
<div>d. INSURANCE PLAN NAME OR PROGRAM NAME</div>				<div>10d. RESERVED FOR LOCAL USE</div>				<div>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, return to and complete item 9 a-d.</div>			
<div style="text-align: center;">READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.</div>											
<div>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.</div>											
<div>SIGNED</div>						<div>DATE</div>					
<div>14. DATE OF CURRENT:</div> <div>MM DD YY</div> <div>ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)</div>						<div>15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE</div> <div>MM DD YY</div>					
<div>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</div>						<div>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</div> <div>FROM MM DD YY TO MM DD YY</div>					
<div>19. RESERVED FOR LOCAL USE</div>						<div>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</div> <div>FROM MM DD YY TO MM DD YY</div>					
<div>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)</div>						<div>20. OUTSIDE LAB?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES</div>					
<div>1. 123 4</div>						<div>22. MEDICAID RESUBMISSION CODE</div> <div>ORIGINAL REF. NO.</div>					
<div>2. </div>						<div>23. PRIOR AUTHORIZATION NUMBER</div>					
<div>24. A. DATE(S) OF SERVICE</div> <div>From MM DD YY To MM DD YY</div>						<div>B. PLACE OF SERVICE</div> <div>EMG</div>					
<div>C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</div> <div>CPT/HCPCS MODIFIER</div>						<div>E. DIAGNOSIS POINTER</div>					
<div>1 10 01 06 41 A0427 RH HR 0100</div>						<div>F. \$ CHARGES</div> <div>100 00 2</div>					
<div>2 10 01 06 41 A0427 RH HR 0100</div>						<div>G. DAYS OR UNITS</div> <div>2</div>					
<div>3 10 01 06 41 A0427 RH HR 0100</div>						<div>H. ICD-9-CM</div> <div>ZZ</div>					
<div>4 10 01 06 41 A0427 RH HR 0100</div>						<div>I. ID. QUAL</div> <div>NPI</div>					
<div>5 10 01 06 41 A0427 RH HR 0100</div>						<div>J. RENDERING PROVIDER ID. #</div> <div>NPI</div>					
<div>6 10 01 06 41 A0427 RH HR 0100</div>						<div>IF APPLICABLE</div>					
<div>25. FEDERAL TAX I.D. NUMBER</div> <div>SSN EIN</div>						<div>26. PATIENT'S ACCOUNT NO.</div> <div>14 DIGITS</div>					
<div>27. ACCEPT ASSIGNMENT?</div> <div>YES <input type="checkbox"/> NO <input type="checkbox"/></div>						<div>28. TOTAL CHARGE</div> <div>\$ 100 00</div>					
<div>29. AMOUNT PAID</div> <div>\$ If Applicable</div>						<div>30. BALANCE DUE</div> <div>If Applicable</div>					
<div>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</div>						<div>32. SERVICE FACILITY LOCATION INFORMATION</div> <div>If applicable</div>					
<div>33. BILLING PROVIDER INFO & PH #</div> <div>Your Place</div> <div>100 Easy Street</div> <div>Anytown, KY 40601</div>						<div>34. PAY TO</div> <div>Pay to NPI</div>					
<div>SIGNED</div>						<div>DATE</div>					
<div>01/01/2012</div>						<div>35. PAY TO</div> <div>ZZ Pay to Taxonomy</div>					

NUCC Instruction Manual available at: www.nucc.org

6.4 Completion of the New CMS-1500 (08/05) Claim Form with NPI and Taxonomy

6.4.1 Detailed Instructions

Claims are returned or rejected if required information is incorrect or omitted. Handwritten claims must be completed in black ink ONLY.

The following fields must be completed:

FIELD NUMBER	FIELD NAME AND DESCRIPTION
2	Patient's Name
	Enter the member's last name and first name exactly as it appears on the Member Identification card.
3	Date of Birth
	Enter the date of birth for the member.
9A	Other Insured's Policy Group Number
	Enter the 10 digit Member Identification number exactly as it appears on the current Member Identification card.
10	Patient's Condition
	Check the appropriate block if the member's condition is related to employment, auto accident, or other accident.
11	Insured's Policy Group or FECA Number
	Required only if member has another insurance in addition to Medicaid or Medicare and the other insurance has made a payment on the claim. Enter the policy number of the other insurance. Also, complete Fields 11c and 29.
	NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from carrier to the submitted claim.
11C	Insurance Plan Name or Program Name
	Required only if member has another insurance in addition to Medicaid or Medicare and the other insurance made a payment on the claim. Enter the name of the other insurance company. Also, complete Fields 11, 29 and 30.
21	Diagnosis or Nature of Illness or Injury
	Enter the appropriate ICD-9-CM diagnosis code.

24A	Date of Service (Non Shaded Area)
	Enter the date in month, day, year format (MMDDYY) for each procedure.
24B	Place of Service (Non Shaded Area)
	Enter the two digit place of service code. 41 - Ambulance-Land; or, 42 - Ambulance- Air or Water (Valid for provider type 55 only).
24D	Procedures, Services or Supplies CPT/ HCPCS (Non Shaded Area)
	Enter the appropriate HIPAA compliant procedure code identifying the service provided for the member.
	Modifiers (Non Shaded Area)
	Enter the appropriate HIPAA compliant two digit modifier that further describes the procedure code. Modifiers are required on each line to indicate location of pickup and destination. *See Appendix for additional modifiers accepted to indicate location of pickup and destination. If modifiers GM, UA, UB, or UC are appropriate in the billing situation, they must be shown in the first modifier field and followed by the modifier showing location of pickup and destination. GM= ADDITIONAL PATIENT UA = ALS mileage UB= BLS mileage UC= Medical first response Up to four modifiers are accepted.
24E	Diagnosis Pointer (Shaded Area)
	Enter Military Time of Pickup
24E	Diagnosis Code Indicator (Non Shaded Area)
	Enter 1, 2, 3, or 4 when referencing the specific diagnosis shown in field 21 to link the diagnosis to the procedure.
24F	Charges (Non Shaded Area)
	Enter the usual and customary base rate charge. Enter the rate per loaded miles times the number of miles per one-way trip (for example, 20 miles at \$1.50 per mile = \$30.00). Enter the actual invoice charges for disposable supplies and/or extra service charges.

24G	Days or Units (Non Shaded Area)
	Enter appropriate number of units. For base rate, oxygen and supplies procedure codes enter "1" for one way or "2" for round trip. For mileage procedure codes, if the trip is one way, enter the actual number of loaded miles.
24I	ID Qualifier (Shaded Area)
	Enter a ZZ to indicate Taxonomy. Provider Type 56 (Non Emergency) follow instructions in previous section on billing without NPI and Taxonomy. NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.
24J	Rendering Provider ID # (Shaded Area)
	Enter the Rendering Provider's Taxonomy Number. Provider Type 56 (Non Emergency) follow instructions in the previous section on billing without NPI and Taxonomy. NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.
	(Non Shaded Area)
	Enter the Rendering Provider's NPI Number. Provider Type 56 (Non Emergency) follow instructions in the previous section on billing without NPI and Taxonomy.
26	Patient's Account No.
	Enter the member account number. HP Enterprise Servicetypes up to 14 digits. This number appears on the remittance statement as the invoice number.
28	Total Charge
	Enter the total of all individual charges entered in Field 24F. Total each claim separately.
29	Amount Paid
	Enter the amount paid, if any, by a private insurance. Do not enter Medicare paid amount. Also, complete Fields 11 and 11c. NOTE: If other insurance denies the claim, leave these fields blank and attach denial statement from the carrier the submitted claim.

30	Balance Due
	Required only if private insurance has made a payment on the claim. Subtract the private insurance payment entered in Field 29 from the total charge entered in Field 28 and enter the net balance due in Field 30.
31	Date
	Enter the date in numeric format (MMDDYY). This date must be on or after the date(s) of service on the claim.
32	Service Facility Location Information
	If the address in Form Locator 33 is not the address where the service was rendered, Form Locator 32 must be completed.
33	Physician/ Supplier's Billing Name, Address, Zip Code and Phone Number
	Enter the provider's name, address, zip code and phone number.
33A	NPI
	Enter the appropriate Pay to NPI Number. Provider Type 56 (Non Emergency) follow instructions in the previous section on billing without NPI and Taxonomy.
33B	(Shaded Area)
	Enter ZZ followed by the appropriate Pay To Taxonomy. Provider Type 56 (Non Emergency) follow instructions in the previous section on billing withough NPI and Taxonomy. NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.

6.5 Military Time Conversions

Military Time Conversions

Military or Universal time is easy to understand after a little practice. There is no AM or PM, the day is divided in 24 hours.

Military Time Conversion Chart

Reg. Time	Military	Reg. Time	Military	Reg.	Military
12:01 AM	0001	11:00 AM	1100	9:00 PM	2100
1:00 AM	0100	12:00 Noon	1200	10:00 PM	2200
2:00 AM	0200	1:00 PM	1300	11:00 PM	2300
3:00 AM	0300	2:00 PM	1400	12:00 Midnight	2400
4:00 AM	0400	3:00 PM	1500		
5:00 AM	0500	4:00 PM	1600		
6:00 AM	0600	5:00 PM	1700		
7:00 AM	0700	6:00 PM	1800		
8:00 AM	0800	7:00 PM	1900		
9:00 AM	0900	8:00 PM	2000		
10:00 AM	1000				

6.6 Helpful Hints For Successful CMS-1500 (08/05) Filing

- Any required documentation for claims processing must be attached to each claim. Each claim is processed separately;
- Be sure the “AS OF” date and “EOB” code appears on the copy of any remittance advice submitted for proof of timely filing or for inquiries concerning claim status;
- Please follow up on the status of any claim that appears to be outstanding after six weeks from your submission date;
- Field 24B (Place of Service) requires a two-digit code; and,
- When entering a modifier in Field 24D on the CMC 1500 (08/05), it is important to enter modifiers GM, UA, UB, or UC in the first position (if applicable), followed by the modifiers showing pickup location and destination. See Appendix B1.
- If any insurance other than Medicare/Medicaid makes a payment on services you are billing, complete Fields 11, 11c, 29 and 30 on the CMS-1500 (08/05) claim form;
- If insurance does not make a payment on services you are billing, attach the private insurance denial to the CMS-1500 claim form. Do not complete Fields 11, 11c, 29, and 30 on the CMS-1500 (08/05) claim form;
- When billing the same procedure code, for the same date of service, you must bill on one line indicating the appropriate units of service;
- When submitting claims for the coinsurance and/or deductible after Medicare payment, do not cut your EOMB into strips. The Medicare paid date on the EOMB must be visible and is required for processing; and,
- If you are submitting a copy of a previously submitted claim on which some line items have paid and some denied, mark through or delete any line(s) on the claim already paid. However, if the base rate procedure is the paid detail, an adjustment must be filed since a base rate procedure is required when billing for oxygen, supplies and/or miles.

NOTE: If you mark through any lines, be sure to recompute your total charge in Field 28 to reflect the new total charge billed.

7 Emergency Authorization

AUTHORIZATION FOR EMERGENCY AMBULANCE SERVICES TO FACILITY OTHER THAN A HOSPITAL EMERGENCY ROOM

I, _____, licensed medical professional at
(Name)

(Medical Facility)

(Address of Facility)

do hereby certify that _____,
(Member Name & MEMBER IDENTIFICATION Number)

required the use of emergency transportation and required and received the

following emergency medical treatment on _____
(Date)

Treatment: _____

Diagnosis: _____

The reason the patient was not transported to the nearest medical facility or hospital emergency room is:

Printed Name of Licensed Medical Professional

Title

Signature of Same

Date

NOTE: This form must be completed in its entirety. The information contained herein is subject to audit by representatives of the Department for Medicaid Services, the Office of the Inspector General and the Health Care Finance Administration (CMS). This form is to be filed, remain in the member's run sheet and produced upon Medicaid post audit review.

8 Appendix A

8.1 Resubmission of Medicare/Medicaid Part B Claims

On claims which have Medicare allowed procedures as well as non-allowed procedures, Medicaid must be billed on separate claims.

1. For services denied by Medicare, attach a copy of Medicare's denial to the claim.
2. If a service was allowed by Medicare, submit a CMS-1500 (08/05), which should be submitted to KY Medicaid according to Medicaid guidelines. To this claim, the provider must attach the corresponding Medicare Coding Sheet.

For claims automatically crossed over from Medicare to KY Medicaid, allow six weeks for processing. If no response is received within six week of the Medicare EOMB date, resubmit per item two.

8.1.1 Medicare Coding

As of September 29, 2008, the Medicare EOMB is no longer needed to be attached to a claim if Medicare pays on the service. Instead of the Medicare EOMB, providers will utilize the coding sheet on the next page.

In the event that Medicare denies your service, the Medicare EOMB will be required to be attached to the claim.

The Medicare Coding Sheet may be accessed at www.kymmis.com. You may type in the Medicare information into the PDF and print the coding sheet so you don't have to hand-write the required information. The PDF will not save your changes in the coding sheet.

Please follow the guidelines below so your Medicare Coding Sheet may process accurately.

- Black ink only. No colored ink, pencils or highlighters;
- No white out. Correction tape is allowed;
- If a service is paid in full by Medicare, those services do not need to be billed to Kentucky Medicaid. The allowed amount and paid amount from Medicare would be the same.
- When writing zeros do not put a line through the zero.
- When billing a claim with multiple detail lines, be sure that Medicare has allowed a payment on those services. If Medicare has denied a detail line, that detail must be on a separate claim with the Medicare EOMB attached.
- The documents must be listed in the following order:
 - Claim form;
 - Coding sheet, and;
 - Any other attachments that may be needed.

8.1.2 Medicare Coding Sheet

CMS1500 CROSSOVER EOMB FORM

Member Name: 1 Member ID: 2

EOMB Date: 3

Line <u>4</u>	Deduct/Pat Resp Amt	Coinsurance and/or Co-pay Amt	Provider Pay Amt
5		6	7
8			

Line <u>4</u>	Deduct/Pat Resp Amt	Coinsurance and/or Co-pay Amt	Provider Pay Amt
5		6	7
8			

Line <u>4</u>	Deduct/Pat Resp Amt	Coinsurance and/or Co-pay Amt	Provider Pay Amt
5		6	7
8			

Line <u>4</u>	Deduct/Pat Resp Amt	Coinsurance and/or Co-pay Amt	Provider Pay Amt
5		6	7
8			

Line <u>4</u>	Deduct/Pat Resp Amt	Coinsurance and/or Co-pay Amt	Provider Pay Amt
5		6	7
8			

Line <u>4</u>	Deduct/Pat Resp Amt	Coinsurance and/or Co-pay Amt	Provider Pay Amt
5		6	7
8			

8.1.3 Medicare Coding Sheet Instructions

FIELD NUMBER	FIELD NAME AND DESCRIPTION
1	Member's Name
	Enter the Member's last name and first name exactly as it appears on the Member Identification card.
2	Member's ID
	Enter the Member's ID as it appears on the claim form.
3	EOMB Date
	Enter Medicare's EOMB date.
4	Line Number
	Enter the line number. The line numbers must be in sequential order.
5	Deductible Amount
	Enter deductible amount from Medicare, if applicable.
6	Co-insurance and/or Co-pay Amount
	Enter the total amount of co-insurance and/or co-pay from Medicare if applicable.
7	Provider Pay Amount
	Enter the amount paid from Medicare
8	Patient Responsibility
	Enter the patient responsibility amount from Medicare

9 Appendix B

9.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP Enterprise Services to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

11 – 10 – 032 - 123456

1 2 3 4

1. Region

10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	INTERNET CLAIMS WITH NO ATTACHMENTS
40	CLAIMS CONVERTED FROM OLD MMIS
45	ADJUSTMENTS CONVERTED FROM OLD MMIS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS - CHECK RELATED
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - PROVIDER RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
57	ADJUSTMENTS - VOID CHECK RELATED

2. Year of Receipt

3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.

4. Batch Sequence Used Internally

10 Appendix C

10.1 Remittance Advice

This section is a step-by-step guide to reading a Kentucky Medicaid Remittance Advice (RA). The following sections describe major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are included, reading the data from left to right, top to bottom.

10.1.1 Examples Of Pages In Remittance Advice

There are several types of pages in a Remittance Advice, including separate page types for each type of claim; however, if a provider does not have activity in that particular category, those pages are not included.

Following are examples of pages which may appear in a Remittance Advice:

FIELD	DESCRIPTION
Returned Claims	This section lists all claims that have been returned to the provider with an RTP letter. The RTP letter explains why the claim is being returned. These claims are returned because they are missing information required for processing.
Paid Claims	This section lists all claims paid in the cycle.
Denied Claims	This section lists all claims that denied in the cycle.
Claims In Process	This section lists all claims that have been suspended as of the current cycle. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider need not resubmit the claims listed in this section.
Adjusted Claims	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
Mass Adjusted Claims	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
Financial Transactions	This section lists financial transactions with activity during the week of the payment cycle.
	NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.

Summary	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
EOB Code Descriptions	Any Explanation of Benefit Codes (EOB) which appear in the RA are defined in this section.

NOTE: For the purposes of reconciliation of claims payments and claims resubmission of denied claims, it is highly recommended that all remittance advices be kept for at least one year.

10.2 Title

The header information that follows is contained on every page of the Remittance Advice.

REPORT: CRA-XBPD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE

DATE: 01/25/2007
PAGE: 2

FIELD	DESCRIPTION
DATE	The date the Remittance Advice was printed.
RA NUMBER	A system generated number for the Remittance Advice.
PAGE	The number of the page within each Remittance Advice.
CLAIM TYPE	The type of claims listed on the Remittance Advice.
PROVIDER NAME	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
PAYEE ID	The eight-digit Medicaid assigned provider ID of the billing provider.
NPI ID	The NPI number of the billing provider.

The category (type of page) begins each section and is centered (for example, *PAID CLAIMS*). All claims contained in each Remittance Advice are listed in numerical order of the prescription number.

10.3 Banner Page

All Remittance Advices have a “banner page” as the first page. The “banner page” contains provider specific information regarding upcoming meetings and workshops, “top ten” billing errors, policy updates, billing changes etc. Please pay close attention to this page.

REPORT: CRA-BANN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
PROVIDER BANNER MESSAGES

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID 99999999
CHECK/EFT NUMBER 99999999
ISSUE DATE 01/26/2007

Commonwealth of Kentucky

REPORT: CRA-BANN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS PAID

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 99999999
ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT

MEMBER NAME: JANE DOE MEMBER NO.: 9999999999

999999999999	060606 060606	200.00		0.00			0.00
99999999XXX			18.05		0.00	2.00	16.05

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	ALLOWED	DETAIL E OBS
				FROM THRU	PROVIDER	AMOUNT	AMOUNT	
22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	18.05	5001 0018 9918 00A2

TOTAL CMS 1500 CLAIMS PAID:	200.00		0.00		0.00		16.05
-----------------------------	--------	--	------	--	------	--	-------

10.4 Paid Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Account Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The allowed amount for Medicaid
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount collected from the member.
COPAY AMOUNT	The amount collected from the member.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS PAID ON THIS RA	The total number of paid claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-BANN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS DENIED

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 000999999
ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	TPL	SPENDDOWN
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999		
2007017999999	060606 060606	200.00	0.00	0.00
99999999XXX				

HEADER EOBS: 3015 0011

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	DETAIL EOBS
				FROM THRU	PROVIDER	AMOUNT	
22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	0145 0011
TOTAL CMS 1500 CLAIMS DENIED:				200.00	0.00	0.00	

10.5 Denied Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-BANN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS 1500 CLAIMS IN PROCESS

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 99999999
ISSUE DATE 01/26/2007

--ICN--	SERVICE DATES	BILLED	TPL
--PATIENT NUMBER--	FROM THRU	AMOUNT	AMOUNT
MEMBER NAME: JANE DOE	MEMBER NO.: 9999999999		
999999999999	060606 060606	200.00	0.00
99999999XXX			

PL SERV	PROC CD	MODIFIERS	UNITS	SERVICE DATES	RENDERING	BILLED	DETAIL EOB
				FROM THRU	PROVIDER	AMOUNT	
22	88304	TC	1.00	060606 060606	MCD 64000000	200.00	

TOTAL CMS 1500 CLAIMS IN PROCESS: 200.00 0.00

10.6 Claims In Process Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 13-digit unique system-generated identification number assigned to each claim by HP Enterprise Services.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.

REPORT: CRA-IPPD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS CLAIMS RETURNED

DATE: 01/30/2007
PAGE: 2

PROVIDER
5555 ANY STREET
CITY, KY 55555-5555

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 99999999
ISSUE DATE 02/02/2007

--ICN-- REASON CODE
999999999999 01

CLAIMS RETURNED: 01

10.7 Returned Claim

FIELD	DESCRIPTION
ICN	The 13-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
REASON CODE	A code denoting the reason for returning the claim.
CLAIMS RETURNED ON THIS RA	The total number of returned claims on the Remittance Advice.

Note: Claims appearing on the “returned claim” page are forthcoming in the mail. The actual claim is returned with a “return to provider” sheet attached, indicating the reason for the claim being returned.

REPORT: CRA-PRAD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CMS CLAIM ADJUSTMENTS

DATE: 12/14/2006
PAGE: 2

HEALTH SERVICES
ATTN: JANE DOE
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID

--ICN--	SERVICE DATES		BILLED	ALLOWED	TPL	SPENDDOWN	CO-PAY	PAID																																							
--PATIENT NUMBER--	FROM	THRU	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT	AMOUNT																																							
MEMBER NAME: JANE DOE																																															
MEMBER NO.: 9999999999																																															
99999999999999	031103	031103	(20.00)		(0.00)		(0.00)																																								
99999				(20.00)		(0.00)		(20.00)																																							
99999999999999	031103	031103	20.00		0.00		0.00																																								
99999				20.00		0.00		20.00																																							
<table border="1"> <thead> <tr> <th>PL</th> <th>SERV</th> <th>PROC</th> <th>CD</th> <th>MODIFIERS</th> <th>UNITS</th> <th>FROM</th> <th>THRU</th> <th>PROVIDER</th> <th>BILLED</th> <th>ALLOWED</th> <th>DETAIL</th> <th>EOBS</th> </tr> <tr> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th>AMOUNT</th> <th>AMOUNT</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>99</td> <td></td> <td>WP101</td> <td></td> <td></td> <td>1.00</td> <td>031103</td> <td>031103</td> <td>MCD 40097065</td> <td>20.00</td> <td>20.00</td> <td>0102</td> <td>0029</td> </tr> </tbody> </table>									PL	SERV	PROC	CD	MODIFIERS	UNITS	FROM	THRU	PROVIDER	BILLED	ALLOWED	DETAIL	EOBS										AMOUNT	AMOUNT			99		WP101			1.00	031103	031103	MCD 40097065	20.00	20.00	0102	0029
PL	SERV	PROC	CD	MODIFIERS	UNITS	FROM	THRU	PROVIDER	BILLED	ALLOWED	DETAIL	EOBS																																			
									AMOUNT	AMOUNT																																					
99		WP101			1.00	031103	031103	MCD 40097065	20.00	20.00	0102	0029																																			
TOTAL NO. OF ADJ: 1																																															
TOTAL CMS 1500 ADJUSTMENT CLAIMS:									0.00	0.00	0.00	0.00																																			
									0.00		0.00	0.00																																			

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).

If a cash refund is submitted, an adjustment **CANNOT** be filed.

If an adjustment is submitted, a cash refund **CANNOT** be filed.

10.8 Adjusted Claims Page

The information on this page reads left to right and does not follow the general headings.

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The amount allowed for this service.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
COPAY AMOUNT	Copay amount to be collected from member.
SPENDDOWN AMOUNT	The amount to be collected from the member.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
PAID AMOUNT	Amount paid.

Note: The ORIGINAL claim information appears first, followed by the NEW (adjusted) claim information.

REPORT: CRA-TRAN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

DATE: 12/26/2006
PAGE: 2

PROVIDER J
PO BOX 5555
CITY, KY 55555-5555

PAYEE ID 99999999
NPI ID 99999999

-----NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS-----

TRANSACTION	PAYOUT	REASON	RENDERING	SVC DATE				
NUMBER	--CCN--	--AMOUNT--	CODE	PROVIDER	FROM	THRU	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

-----NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS-----

	REFUND	REASON		
--CCN--	--AMOUNT--	CODE	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

-----ACCOUNTS RECEIVABLE-----

A/R	SETUP	RECOUPED	ORIGINAL	TOTAL	REASON	
NUMBER/ICN	DATE	THIS CYCLE	AMOUNT	-RECOUPED-	--BALANCE--	CODE
1106	011306	0.00	22.41	0.00	22.41	92
TOTAL BALANCE					22.41	

10.9 Financial Transaction Page

10.9.1 Non-Claim Specific Payouts To Providers

FIELD	DESCRIPTION
TRANSACTION NUMBER	The tracking number assigned to each financial transaction.
CCN	The cash control number assigned to refund checks for tracking purposes.
PAYMENT AMOUNT	The amount paid to the provider when the financial reason code indicates money is owed to the provider.
REASON CODE	Payment reason code.
RENDERING PROVIDER	Rendering provider of service.
SERVICE DATES	The From and Through dates of service.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

10.9.2 Non-Claim Specific Refunds From Providers

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
REFUND AMOUNT	The amount refunded by provider.
REASON CODE	The two byte reason code specifying the reason for the refund.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

10.9.3 Accounts Receivable

FIELD	DESCRIPTION
A / R NUBMER / ICN	This is the 13-digit Internal Control Number used to identify records for one accounts receivable transaction.
SETUP DATE	The date entered on the accounts receivable transaction in the MM/DD/CCYY format. This date identifies the beginning of the accounts receivable event.

RECOUPED THIS CYCLE	The amount of money recouped on this financial cycle.
ORIGINAL AMOUNT	The original accounts receivable transaction amount owed by the provider.
TOTAL RECOUPED	This amount is the total of the providers checks and recoupment amounts posted to this accounts receivable transaction.
BALANCE	The system generated balance remaining on the accounts receivable transaction.
REASON CODE	A two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a providers account.

ANY RECOUPMENT ACTIVITY OR PAYMENTS RECEIVED FROM THE PROVIDER list below the "RECOUPMENT PAYMENT SCHEDULE." All initial accounts receivable allow 60 days from the "setup date" to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

This is your only notification of an accounts receivable setup. Please keep all Accounts Receivable Summary pages until all monies have been satisfied.

REPORT: CRA-SUMM-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 02/01/2007
PAGE: 13

PROVIDER

P O BOX 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

-----CLAIMS DATA-----

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TD NUMBER	MONTH-TD AMOUNT	YEAR-TD NUMBER	YEAR-TD AMOUNT
CLAIMS PAID	43	130,784.46	43	130,784.46	1,988	4,143,010.13
CLAIM ADJUSTMENTS	0	0.00	0	0.00	18	0.00
MASS ADJUSTMENTS	0	0.00	0	0.00	0	0.00
TOTAL CLAIMS PAYMENTS	43	130,784.46	43	130,784.46	2,006	4,143,010.13
CLAIMS DENIED	1		1		917	
CLAIMS IN PROCESS	2					

-----EARNINGS DATA-----

PAYMENTS:			
CLAIMS PAYMENTS	130,784.46	130,784.46	4,143,010.13
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(0.00)	(44,474.35)
NON-CLAIM SPECIFIC OFFSETS	(0.00)	(0.00)	(0.00)
NET PAYMENT	130,784.46	130,784.46	4,098,535.78
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)
OTHER FINANCIAL:			
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
VOIDS	(0.00)	(0.00)	(0.00)
NET EARNINGS	130,784.46	130,784.46	4,098,535.78

REPORT: CRA-EOBM-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

DATE: 02/01/2007
PAGE: 14

PROVIDER

P O BOX 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

EOB CODE EOB CODE DESCRIPTION

0022 COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
0271 CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE
CONTACT DMS AT 502-564-6885.
0409 INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
0883 CLAIM DENIED. DEPLICATE PROCEDURE HAS BEEN PAID.
9999 PROCESSED PER MEDICAID POLICY

HIPAA REASON CODE HIPAA ADJ REASON CODE DESCRIPTION

0016 Claim/service lacks information which is needed for adjudication. Additional information is supplied
using remittance advice remarks codes whenever appropriate
0018 Duplicate claim/service.
0052 The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the
service billed.
0092 Claim Paid in full.
00A1 Claim denied charges.

10.10 Summary Page

FIELD	DESCRIPTION
CLAIMS PAID	The number of paid claims processed, current month and year to date.
CLAIM ADJUSTMENTS	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
PAID MASS ADJ CLAIMS	<p>The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section.</p> <p>Mass Adjustments are initiated by Medicaid and HP Enterprise Services for issues that affect a large number of claims or providers. These adjustments have their own section "MASS ADJUSTED CLAIMS" page, but are formatted the same as the ADJUSTED CLAIMS page.</p>
CLAIMS DENIED	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
CLAIMS IN PROCESS	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

10.10.1 Payments

FIELD	DESCRIPTION
CLAIMS PAYMENT	The number of claims paid.
SYSTEM PAYOUTS	Any money owed to providers.
NET PAYMENT	Net payment amount.
REFUNDS	Any money refunded to Medicaid by a provider.

OTHER FINANCIAL	
NET EARNINGS	Total check amount.

EXPLANATION OF BENEFITS

FIELD	DESCRIPTION
EOB	A five-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
EOB CODE DESCRIPTION	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an EOB Code is detailed on the Remittance Advice.

EXPLANATION OF REMARKS

FIELD	DESCRIPTION
REMARK	A five-digit number denoting the remark identified on the Remittance Advice.
REMARK CODE DESCRIPTION	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times a Remark Code is detailed on the Remittance Advice.

EXPLANATION OF ADJUSTMENT CODE

FIELD	DESCRIPTION
ADJUSTMENT CODE	A two-digit number denoting the reason for returning the claim.
ADJUSTMENT CODE DESCRIPTION	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an adjustment Code is detailed on the Remittance Advice.

EXPLANATION OF RTP CODES

FIELD	DESCRIPTION
RTP CODE	A two-digit number denoting the reason for returning the claim.
RETURN CODE DESCRIPTION	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an RTP Code is detailed on the Remittance Advice.

11 Remittance Advice Location Codes (LOC CD)

The following is a code indicating the Department for Medicaid Services branch/division or other agency that originated the Accounts Receivable:

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
T	Active Provider A/R Transfer
U	HP Enterprise Services On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

12 Appendix E

12.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

The following is a two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a provider's account:

01	Prov Refund – Health Insur Paid	27	Recoupment – Billing Error
02	Prov Refund – Member/Rel Paid	28	Recoupment – Cost Settlement
03	Prov Refund – Casualty Insu Paid	29	Recoupment – Duplicate Payment
04	Prov Refund – Paid Wrong Vender	30	Recoupment – Paid Wrong Vendor
05	Prov Refund – Apply to Acct Recv	31	Recoupment – SURS
06	Prov Refund – Processing Error	32	Payout – Advance to be Recouped
07	Prov Refund-Billing Error	33	Payout – Error on Refund
08	Prov Refund – Fraud	34	Payout – RTP
09	Prov Refund – Abuse	35	Payout – Cost Settlement
10	Prov Refund – Duplicate Payment	36	Payout – Other
11	Prov Refund – Cost Settlement	37	Payout – Medicare Paid TPL
12	Prov Refund – Other/Unknown	38	Recoupment – Medicare Paid TPL
13	Acct Receivable – Fraud	39	Recoupment – DEDCO
14	Acct Receivable – Abuse	40	Provider Refund – Other TLP Rsn
15	Acct Receivable – TPL	41	Acct Recv – Patient Assessment
16	Acct Recv – Cost Settlement	42	Acct Recv – Orthodontic Fee
17	Acct Receivable – HP Enterprise Services Request	43	Acct Receivable – KENPAC
18	Recoupment – Warrant Refund	44	Acct Recv – Other DMS Branch
19	Act Receivable-SURS Other	45	Acct Receivable – Other
20	Acct Receivable – Dup Payt	46	Acct Receivable – CDR-HOSP-Audit
21	Recoupment – Fraud	47	Act Rec – Demand Paymt Updt 1099
22	Civil Money Penalty	48	Act Rec – Demand Paymt No 1099
23	Recoupment – Health Insur TPL	49	PCG
24	Recoupment – Casualty Insur TPL	50	Recoupment – Cold Check
25	Recoupment – Member Paid TPL	51	Recoupment – Program Integrity Post Payment Review Contractor A
26	Recoupment – Processing Error	52	Recoupment – Program Integrity Post Payment Review Contractor B

53	Claim Credit Balance	75	Withhold-PCP Data Unacceptable
54	Recoupment – Other St Branch	76	Withhold-Other
55	Recoupment – Other	77	A/R Member IPV
56	Recoupment – TPL Contractor	78	CAP Adjustment-Other
57	Acct Recv – Advance Payment	79	Member Not Eligible for DOS
58	Recoupment – Advance Payment	80	Adhoc Adjustment Request
59	Non Claim Related Overage	81	Adj Due to System Corrections
60	Provider Initiated Adjustment	82	Converted Adjustment
61	Provider Initiated CLM Credit	83	Mass Adj Warr Refund
62	CLM CR-Paid Medicaid VS Xover	84	DMS Mass Adj Request
63	CLM CR-Paid Xover VS Medicaid	85	Mass Adj SURS Request
64	CLM CR-Paid Inpatient VS Outp	86	Third Party Paid – TPL
65	CLM CR-Paid Outpatient VS Inp	87	Claim Adjustment – TPL
66	CLS Credit-Prov Number Changed	88	Beginning Dummy Recoupment Bal
67	TPL CLM Not Found on History	89	Ending Dummy Recoupment Bal
68	FIN CLM Not Found on History	90	Retro Rate Mass Adj
69	Payout-Withhold Release	91	Beginning Credit Balance
71	Withhold-Encounter Data Unacceptable	92	Ending Credit Balance
72	Overage .99 or Less	93	Beginning Dummy Credit Balance
73	No Medicaid/Partnership Enrollment	94	Ending Dummy Credit Balance
74	Withhold-Provider Data Unacceptable		

13 Appendix F

13.1 Remittance Advice Status Code (ST CD)

The following is a one-character code indicating the status of the accounts receivable transaction:

A	Active
B	Hold Recoup - Payment Plan Under Consideration
C	Hold Recoup - Other
D	Other-Inactive-FFP-Not Reclaimed
E	Other – Inactive - FFP
F	Paid in Full
H	Payout on Hold
I	Involves Interest – Cannot Be Recouped
J	Hold Recoup Refund
K	Inactive-Charge off – FFP Not Reclaimed
P	Payout – Complete
Q	Payout – Set Up In Error
S	Active - Prov End Dated
T	Active Provider A/R Transfer
U	HP Enterprise Services On Hold
W	Hold Recoup - Further Review
X	Hold Recoup - Bankruptcy
Y	Hold Recoup - Appeal
Z	Hold Recoup - Resolution Hearing

14 Appendix G

14.1 Transportation Pickup and Destination Modifiers

Ambulance/Transportation Origin and Destination Modifiers	
D	Diagnostic or therapeutic site other than 'P' or 'H'
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between types of ambulance
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.).
Note: Modifier X can only be used as a designation code in the second position of a modifier.	

Possible HIPAA Transportation Modifiers and Descriptions	
RD	Residence to Diagnostic or therapeutic site
RE	Residence to Residential, domiciliary, custodial facility
RG	Residence to Hospital-based dialysis facility
RH*	Residence to Hospital
RI	Residence to Site of transfer between types of ambulance
RJ	Residence to Non-hospital based dialysis facility
RN	Residence to Skilled nursing facility (SNF)
RP	Residence to Physician's office
RX	Residence to Intermediate stop at physician's office enroute to the hospital
PD	Physician's office to Diagnostic or therapeutic site
PE	Physician's office to Residential, domiciliary, custodial facility
PG	Physician's office to Hospital-based dialysis facility
PH*	Physician's office to Hospital
PI	Physician office to site of transfer
PJ	Physician's office to Non-hospital based dialysis facility
PN	Physician's office to Skilled nursing facility (SNF)

PP	Physician's office to Physician's office
PR	Physician's office to Residence
PX	Physician's office to Intermediate stop at physician's office enroute to the hospital
HD	Hospital to Diagnostic or therapeutic site
HE	Hospital to Residential, domiciliary, custodial facility
HG	Hospital to Hospital-based dialysis facility
HH	Hospital to Hospital
HI	Hospital to site of transfer
HJ	Hospital to Non-hospital based dialysis facility
HN	Hospital to Skilled nursing facility (SNF)
HP	Hospital to Physician's office
HR	Hospital to Residence
HX	Hospital to Intermediate stop at physician's office enroute to the hospital
ED	Residential, domiciliary, custodial facility to Diagnostic or therapeutic site
EE	Residential, domiciliary, custodial facility to Residential, domiciliary, custodial facility
EG	Residential, domiciliary, custodial facility to Hospital-based dialysis facility
EH	Residential, domiciliary, custodial facility to Hospital
EI	Residential, domiciliary, custodial facility to site of transfer

EJ	Residential, domiciliary, custodial facility to Non-hospital based dialysis facility
EN	Residential, domiciliary, custodial facility to Skilled nursing facility (SNF)
EP	Residential, domiciliary, custodial facility to Physician's office
ER	Residential, domiciliary, custodial facility to Residence
EX	Residential, domiciliary, custodial facility to Intermediate stop at physician's office enroute to the hospital
ND	Skilled nursing facility (SNF) to Diagnostic or therapeutic site
NE	Skilled nursing facility (SNF) to Residential, domiciliary, custodial facility
NG	Skilled nursing facility (SNF) to Hospital-based dialysis facility
NH*	Skilled nursing facility (SNF) to Hospital
NI	Skilled nursing facility to site of transfer
NJ	Skilled nursing facility (SNF) to Non-hospital based dialysis facility
NN	Skilled nursing facility (SNF) to Skilled nursing facility (SNF)
NP	Skilled nursing facility (SNF) to Physician's office
NR	Skilled nursing facility (SNF) to Residence
NX	Skilled nursing facility (SNF) to Intermediate stop at physician's office enroute to the hospital
DD	Diagnostic or therapeutic site to Diagnostic or therapeutic site
DE	Diagnostic or therapeutic site to Residential, domiciliary, custodial facility
DG	Diagnostic or therapeutic site to Hospital-based dialysis facility

DH*	Diagnostic or therapeutic site to Hospital
DI	Diagnostic or therapeutic site to site of transfer
DJ	Diagnostic or therapeutic site to Non-hospital based dialysis facility
DN	Diagnostic or therapeutic site to Skilled nursing facility (SNF)
DP	Diagnostic or therapeutic site to Physician's office
DR	Diagnostic or therapeutic site to Residence
DX	Diagnostic or therapeutic site to Intermediate stop at physician's office enroute to the hospital
SH*	Scene of accident or acute event to Hospital
SI	Scene of accident or acute event to transfer between types of ambulances
SX	Scene of accident or acute event to Intermediate stop at physician's office enroute to the hospital
IH*	Site of transfer between types of ambulance to Hospital
IX	Site of transfer between types of ambulance to Intermediate stop at physician's office enroute to the hospital
II	Site of transfer between types of ambulance to Site of transfer between types of ambulance
GD	Hospital-based dialysis facility to Diagnostic or therapeutic site
GE	Hospital-based dialysis facility to Residential, domiciliary, custodial facility
GG	Hospital-based dialysis facility to Hospital-based dialysis facility
GH	Hospital-based dialysis facility to Hospital
GI	Hospital-based dialysis facility to Site of transfer between types of ambulance

GJ	Hospital-based dialysis facility to Non-hospital based dialysis facility
GN	Hospital-based dialysis facility to Skilled nursing facility (SNF)
GP	Hospital-based dialysis facility to Physician's office
GR	Hospital-based dialysis facility to Residence
GX	Hospital-based dialysis facility to Intermediate stop at physician's office enroute to the hospital
JD	Non-hospital based dialysis facility to Diagnostic or therapeutic site
JE	Non-hospital based dialysis facility to Residential, domiciliary, custodial facility
JG	Non-hospital based dialysis facility to Hospital-based dialysis facility
JH	Non-hospital based dialysis facility to Hospital
JI	Non-hospital based dialysis facility to Site of transfer between types of ambulance
JJ	Non-hospital based dialysis facility to Non-hospital based dialysis facility
JN	Non-hospital based dialysis facility to Skilled nursing facility (SNF)
JP	Non-hospital based dialysis facility to Physician's office
JR*	Non-hospital based dialysis facility to Residence
JX	Non-hospital based dialysis facility to Intermediate stop at physician's office enroute to the hospital